University Hospitals of North Midlands NHS Trust

**Executive Suite**
Trust Headquarters
Springfield
City General Site
Newcastle Road
Stoke on Trent
ST4 6QG

[redacted] [redacted]

12 December 2023

**STRICTLY PRIVATE & CONFIDENTIAL**
Mrs Emma Serrano
H M Area Coroner
Stoke on Trent and North Staffordshire

[redacted]

[redacted]

Dear Mrs Serrano

**Mrs Myra MAXFIELD**

Further to your letter dated 25 October 2023, I am pleased to provide a response under paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, addressing your concerns surrounding the death of Myra Maxfield.

**Recorded Circumstances of the Death**
On the 1st April 2022, you commenced an investigation into the death of Myra Maxfield.

The investigation concluded at the end of the inquest on 15th September 2023. The conclusion of the inquest was a short narrative conclusion of: Complications following a fall on a background of natural causes.

The cause of death was:

1a) Upper gastrointestinal bleed
1b) Infected pressure ulcer following hip arthroplasty
1c) Fall
II) Frailty of old age

**Concerns**
During the course of the inquest you felt that evidence revealed matters giving rise for concern. In your opinion, matters for concern are as follows:

1. Evidence emerged during the inquest that it was crucial that patients who were at risk of developing pressure ulcers, had ulcers already, or had developed them whilst in hospital, saw the Tissue Viability Team as soon as possible, and usually within 6 hours.

2. It was said that delays in doing so could be causative in the death of patients.

3. Evidence emerged that at the Royal Stoke University Hospital, Tissue Viability is not available over the weekend and this leads to substantial delays in patients being seen.

You reported this matter under Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

In your opinion, action should be taken to prevent future deaths.

**Response:**

1. As a point of clarification on the issues that you have raised in Point 1 of your letter, regarding the fact that 'it was crucial that patients who were at risk of developing pressure ulcers, had ulcers already, or had developed them whilst in hospital, saw the Tissue Viability Team as soon as possible, and usually within 6 hours'.

The NICE Pressure Ulcer Quality Standard (QS89), dated 2015: Pressure Ulcer Risk Assessment in Hospitals and Care Homes with Nursing, states that people admitted to a hospital or care home (with nursing) have a pressure ulcer risk assessment within 6 hours of admission. This is an important point of clarity, which differs from your statement that patients should be seen by the Specialist Tissue Viability Team within 6 hours of admission.

At UHNM, like other acute Trusts, The Pressure Ulcer Risk Assessment is completed by the admitting Ward/Department Registered Nurse within 6 hours of admission and 6 hours of transfer to another inpatient area. This is reflected in UHNM Trust Policy C63, Prevention and Management of Pressure Ulcers.

2. Delays may be causative in the death of patients.

Although, it is deemed best practice to complete the Pressure Ulcer Risk Assessment within 6 hours of admission/transfer a delay in completing the initial assessment may not necessarily be causative in the death of patients, as stated in Point 2 of your letter as the patient's outcome would very much depend upon the standard of care delivered thereafter. It is current practice at UHNM to consider all patients admitted to the Emergency Department as being high risk of developing pressure ulcers so that optimal mitigating interventions are delivered in a timely manner.

Referral criteria for Ward/Department Teams to refer patients to the Tissue Viability Team for specialist advice and support is available on the UHNM Trust Intranet pages.

3. Evidence emerged that at the Royal Stoke University Hospital, Tissue Viability is not available over the weekend and this leads to substantial delays in patients being seen.

Mrs Maxfield was admitted to UHNM at 14:15 hrs on Friday 3rd December 2021 with an existing Category 4 Pressure Ulcer, to the spinal area, which already had a dressing in place. In the evidence presented in court it was acknowledged that there was a delay in the initial Pressure Ulcer Risk Assessment, which was assessed and documented within 11 hours of admission (as opposed to 6 hours). This was due to high staffing acuity and clinical demand during the Covid-19 Pandemic, where direct patient care was prioritised over documentation. However, it should be noted that the Pressure Ulcer was already present and had a dressing in situ during this time. An incident report was completed (ID:259932), clinical photography requested and a safeguarding referral was made within the Department, which is deemed good practice.

The Spinal Team reviewed Mrs Maxfield and requested an MRI scan to rule out osteomyelitis and promptly commenced intravenous antibiotics.

Mrs Maxfield was referred to the Specialist Tissue Viability Team for advice about management of the existing Category 4 Pressure Ulcer on Saturday 4th December 2021 and subsequently reviewed on the next day, Sunday 5th December 2021. Ordinarily, a Category 4 Pressure Ulcer identified on admission would be reviewed by the Tissue Viability Team within 1-3 working days and on this occasion Mrs Maxfield was reviewed within 1 working day as the team were on site during that particular weekend, due to extenuating circumstances within the Trust. In addition, Mrs Maxfield was reviewed and followed up by the Tissue Viability Team on 14th December 2021 and 23rd December 2021 prior to her discharge on 23rd December 2021.

We strive to provide a high standard of care to all of our patients and preventing avoidable pressure ulcers and managing existing pressure ulcers, as in the case of Mrs Maxfield, is an important quality metric. People in hospital can be at higher risk of pressure ulcer damage but we have a range of support for teams to minimise the risk of pressure ulcer development or deterioration. UHNM provide a regular 5-Day (Monday – Friday) Tissue Viability Service, which is in line with most acute Trusts nationally. However, as demonstrated in the case of Mrs Maxwell, a limited service is provided at weekends in extenuating circumstances on an ad hoc basis. As presented to your court by [redacted] Lead Clinical Nurse Specialist for Tissue Viability and Continence, the risk of not providing a routine Tissue Viability Service at weekends is mitigated by having pathways, policies and guidance to support frontline clinicians with pressure ulcer prevention and management of existing pressure ulcers out of hours. Training in all aspects of pressure ulcer prevention and ongoing management is provided to Ward/Departmental staff.

In response to your concerns, we will continue to monitor the timeliness of pressure ulcer risk assessment completion by our Ward/Department teams via our monthly Tendable Care Excellence audits. We will also ensure that the referral criteria for Ward/Department Teams to refer patients to the Tissue Viability Team for specialist advice and support is reviewed and included in UHNM Trust Policy C63, Prevention and Management of Pressure Ulcers. We will subsequently monitor referral to response times, according to the severity of the Pressure Ulcer, by our Specialist Tissue Viability Team.

I do hope that the above information provides assurance that the Trust has taken the concerns raised at the inquest seriously.

Should you wish to discuss any aspect of this report further, please do not hesitate to contact me directly.

Yours sincerely

[redacted]
**CHIEF EXECUTIVE**